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Consistency of Autobiographical Memories in Asylum Seekers

TO THE EDITOR: When applying for asylum in a new country, refugees are interviewed by immigration authorities about events they experienced prior to emigrating. Since there is usually no documentary evidence regarding past traumatic events experienced in the country of origin, legal decision pertaining to status may rest on the credibility of the applicant's narrative. If an applicant gives different (discrepant) accounts of their experiences on different occasions, it is easy to assume that they have fabricated a story in an attempt to obtain a residency permit (1). However, a study of a sample of 39 asylum seekers from the Balkans in the United Kingdom has convincingly shown that such inconsistencies between different interviews should not be relied upon as indicating a lack of sincerity or credibility among asylum seekers. Indeed, discrepancies occur even when there is no reason for fabrication. More precisely, Herlihy et al. (2) demonstrated that inconsistent accounts were associated with the presence of posttraumatic stress symptoms in this sample.

In Switzerland, similar to most countries, the process of claiming asylum comprises several oral interviews with representatives of the immigration administration. A large proportion of asylum seekers come from Africa. These individuals have often experienced lasting traumatic events (e.g., political persecutions, war).

We assessed seven French- or English-speaking asylum seekers from sub-Saharan West Africa. All subjects had been exposed to at least one potentially traumatic event. They were asked to recall and narrate a traumatic event and a happy event of their choice on two different occasions, with a 6-week interval between the repeated narrations. A structured interview, adapted from Herlihy et al. and investigating the characteristics of the event, autobiographical memories, and intrusive thoughts pertaining to the event, was used. Participants also completed two self-report scales: the Impact of Event Scale and the Hospital Anxiety and Depression Scale. The Impact of Event Scale is a 15-item scale that assesses subjective distress after a stressful life event.

Subjects were 18 to 50 years of age (mean=26.85 years). The time between the traumatic event and arrival in Switzerland was 4 months. Consistency was assessed by comparing responses to the structured interview at the first and second evaluation. The percentage of identical responses was recorded. In this sample, consistency was not different for happy and traumatic events (82.9% and 82.3%, respectively). However, interindividual variability was greater for happy relative to traumatic memories, with higher distress scores on the Impact of Event Scale being associated with decreased consistency of happy event narratives (p=0.04). There was no significant association between memories of events and Hospital Anxiety and Depression Scale scores. Overall, discrepancies between an individual's accounts were not common.

Contrary to previous findings, our results do not show a significant distortion of traumatic memories compared with happy memories. Apart from the small sample size, differences in administrative procedures between different host countries could explain these results. In our country, individuals seeking asylum have to relate traumatic events orally on several occasions. This could increase the coherence of narratives. Additionally, consistency of traumatic memories between European and African subjects may differ. Relationships between the consistency of autobiographic memories and types of events (traumatic versus happy) appear to be mediated by affective factors such as perceived distress. These preliminary results should be tested in larger samples. Indeed, given the high number of displaced and traumatized individuals worldwide, these issues have important ethical and public health implications.

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Electroconvulsive Therapy in a Patient With Concomitant Depression and Charcot-Marie-Tooth Disease

TO THE EDITOR: Charcot-Marie-Tooth disease is a severe neurological disorder affecting both motor and sensory peripheral nerves. In patients with peripheral autonomic nervous or respiratory system involvement, anesthesia management can be difficult. A higher risk for malignant hyperthermia and succinylcholine-induced hyperkalemia during anesthesia in patients with Charcot-Marie-Tooth disease is under discussion (1, 2). These issues may limit the possibility for psychiatric patients with Charcot-Marie-Tooth disease to undergo electroconvulsive therapy (ECT). We present the first case of a successful performance of ECT in a patient suffering from both severe treatment-resistant depression and Charcot-Marie-Tooth disease.

"Mr. T," a 70-year-old man suffering from Charcot-Marie-Tooth disease type I, with pronounced muscle atrophy in the upper and lower extremities, was referred to our department with severe, delusional, first-episode depression. For almost 2 years, a loss of drive, delusions of poverty, and near mutism were the most prominent symptoms. Since the patient had previously been resistant to any antidepressant (citalopram, clomipramine, duloxetine, mirtazapine, paroxetine, reboxetine, tranylcypromine) or antipsychotic (haloperidol, olanzapine, quetiapine, risperidone), we decided to perform ECT.

Electroencephalography and magnetic resonance imaging did not reveal any pathology. Blood gas analysis showed a slight compensated respiratory acidosis (PaO_2=83 mmHg, $PaCO_2$=44 mmHg, pH=7.41, HCO_3=27 mmol/l, BE= –0.9

mmol/l). Both body plethysmographic and spirometric measurements were normal, with regular vital capacity (4.27 l, 102% predicted) and Tiffeneau index (85%, 114% predicted).

The patient received eight unilateral and seven bitemporal electroconvulsive treatments (bidirectional: 309 to 622 mC; length of stimulus train: 5.2 to 8 seconds) over a period of 6 weeks. Concomitant antidepressant and antipsychotic medications (reboxetine, 4 mg; risperidone 2 mg per day) were continued during ECT. Anesthesia was induced with intravenous propofol (2.5 mg/kg) and mivacurium (0.1 mg/kg), followed by oxygenation, with 100% oxygen for 4 minutes. Severity of depression was assessed using the 21-item Hamilton Depression Rating Scale (HAM-D) every 14 days during ECT treatment.

Except for several short episodes of bradycardia (minimum 42 bpm) during anesthesia and a delayed recovery phase after ECT (approximately 10 minutes), no significant complications occurred during anesthesia and ECT, nor were there any cognitive disturbances. Within a few sessions, the patient showed improved mood and a clear increase in drive and social activity. His HAM-D score decreased from 36 at baseline to 22 by the end of ECT treatment. This effect has been sustained with lithium and bupropion following ECT for more than 6 months.

To our knowledge, this is the first report of ECT in a patient suffering from concomitant Charcot-Marie-Tooth disease. Thus, with adequate prearrangement, ECT can safely be performed in patients suffering from both Charcot-Marie-Tooth disease and pharmacotherapy-resistant psychiatric disorders. Nevertheless, ECT anesthesia procedures should be standardized based on systematic evaluations.

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Corrections

At the time it was published online on April 1, 2008, the article "Evaluation of the Risk of Congenital Cardiovascular Defects Associated With Use of Paroxetine During Pregnancy" by Adrienne Einarson et al. (doi: 10.1176/appi.ajp.2007.07060879) did not include some financial relationships. The version that appears in print includes these relationships, and the online version has been corrected.

In the article "Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Outpatients With Borderline Personality Disorder: A Randomized Controlled Trial and 1-Year Follow-Up," by Nancee Blum, M.S.W., et al. (Am J Psychiatry 2008; 165:468–478 [doi: 10.1176/appi.ajp.2007.07071079]), in Table 2, in the column for characteristics, "current major depressive disorder" should have been listed as "lifetime major depression."

In the article "Double-Blind, Placebo-Controlled Study of Dialectical Behavior Therapy Plus Olanzapine for Borderline Personality Disorder," by Joaquim Soler, Psy.D., and colleagues (Am J Psychiatry 2005; 162:1221–1224), the footnote should read "From the Department of Psychiatry, Sta. Creu and St. Pau Hospital, and the Universidad Autónoma de Barcelona (UAB)."

In the article by Eduard Vieta, M.D., Ph.D., et al. ("Efficacy of Adjunctive Aripiprazole to Either Valproate or Lithium in Bipolar Mania Patients Partially Nonresponsive to Valproate/Lithium Monotherapy: A Placebo-Controlled Study," published online April 1, 2008; doi:10.1176/appi.ajp.2008.07101560), the mean changes from baseline in Figure 2 did not correspond with the data provided by the authors, which showed a greater degree of change over 6 weeks. Also, in Figure 3 the endpoint of the Young Mania Rating Scale was incorrect. The PDF version now online indicates that it differs from what was first posted in that Figure 2 has been modified to accurately reflect the greater degree of change seen in the study and the endpoint of the Young Mania Rating Scale in Figure 3 has been corrected. When the article appears in print, the online version of the article will be updated to reflect the issue page numbers and Figure 2 and Figure 3 will appear as they were intended.